Capitol Cardiology ASSOCIATES

COMPLETE ALL SHADED AREAS

PATIENT INFORMATION **TODAYS DATE:**_____

NAME:_____ _____ _____**DOB:**___/___/_____**SEX: M/F**
First M.I. Last Mo Day Year

Social Security#_____**Marital Status:**_____

EMAIL ADDRESS:_____ **(Information is for OUR USE ONLY)**

Mailing Address:_____**Home #**_____

_____**Cell #**_____

Employer:_____**Work #**_____

EMERGENCY CONTACT (MUST HAVE): _____**Relation:**_____

Daytime PH#:_____**Evening#:**_____**Cell#:**_____

INSURANCE INFORMATION:

Primary Insurance Carrier:_____**Tel #:**_____

ID #:_____**GRP #:**_____**Subscriber:**_____

Secondary Insurance Carrier:_____**Tel #:**_____

ID #:_____**GRP #:**_____**Subscriber:**_____

Does patient have any other insurance?: Yes / No If yes, please put Name,Address, Tele#, Policy ID#, and GRP # on the back of this form

SPOUSE INFORMATION:

NAME:_____ _____ _____**DOB:**_____/____/_____**SEX: M/F**
First M.I. Last Mo Day Year

Employer:_____**Work #**_____**Cell#:**_____

Do you live at the same address as the patient?: Yes / No If NO, plesase complete below:

Address:_____**Home:#**_____

SIGNATURE ON FILE:

I AUTHORIZE (1) Use of my signature on all my insurance submissions,(2)Release of info to all my insurance companies,(3)My doctor to act as my agent in helping me obtain payment from my insurance carrier,(4)Payment made directly to Capitol Cardiology Assoc.,(5)Permit a copy of this authorization to be used in place of the original, and(6)I understand that I AM RESPONSIBLE FOR MY BILL.

PRINT Name:_____**Medicare #:**_____
(if applies)

SIGNATURE:_____**DATE:**_____

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NOTICE OF PRIVACY PRACTICES

Capitol Cardiology Associates (CCA) will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other healthcare operations. Healthcare operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies about your personal health information. Upon request we can give you a copy of this policy after signing the consent.

The terms of the notice may change with time and we will always post the current notice at our facilities and have copies available for distribution.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply)

___**Home#** _____ **Cell#**_____

___ **If you want us to speak to another person about your health issues, please list their name(s) below:**

Other person:_____

_____

___**Other physicians, OK To fax/mail records to:**

_____ _____ _____
Doctor Name Phone# Fax#

_____ _____ _____
Doctor Name Phone# Fax#

****

I, (please print)_____, have been offered a copy of CCA facilities Notice of Privacy Practices (located at front check-in desk).

_____ _____
Signature **Today's Date**

FOR OFFICE USE ONLY

CCA attempted to obtain written acknowledgement of our Privacy Practices, but acknowledgement could not be obtained because of the following:

___Individual refused ___Communication barriers ___Emergency situation ___Other_____

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Name: _____ **DOB:** _____ **DATE:**_____

Reason for visit:_____

Medication Allergies:_____

Social History:

Do you use recreational Drugs?? **YES / NO** What kind?_____

Do you drink ALCOHOL?? **YES / NO** What kind? _____how many?_____per wk

Tobacco	**Packs Daily:**		**COFFEE:**	**Cups Daily:**		**Sleep:**	**Difficulty Falling**	
Use?	**How Long?**		**Other**	**Caffeine:**			**Snoring**	
Yes / No	**Interested in Stopping??**		**Energy**	**Drinks: Supplements:**			**Continuity/Wake Up Disturbances**	

Family History: (Please circle & list any health problems and cause of death age,etc)

Father: Age:	Heart Attack \ Stroke \ Sudden Cardiac Death\
Mother: Age:	Heart Attack \ Stroke \ Sudden Cardiac Death
Siblings:	
Grandparents – Mother:	
Grandparents – Father:	

Personal Medical History: (Yes/No)

Chest Discomfort		**Stroke / Mini Stroke**		**Depression / Anxiety**	
Shortness of Breath		**DVT Deep Vein Thrombosis**		**Ulcer / Stomach Problems**	
Heart Palpitations		**PE Pulmonary Embolism**		**Incontinence**	
Heart Murmur		**Sudden Cardiac Death**		**Sexual or Menstrual Dysfunction**	
Pains in Leg(s)		**Cardiac Cath (in Groin)**		**Rheumatic/ Scarlet Fever**	
Dizziness/fainting		**Cardiac Bypass or Stents**		**Allergies/Hay Fever**	
Peripheral Vascular OR Artery Disease		**Cardiac Stress Treadmill Test**		**Asthma / Bronchitis**	
High Blood Pressure		**Prostate Disease**		**Pneumonia**	
High Cholesterol		**Headaches**		**Circle all that applies Polio/Mumps/Measles**	
Diabetes		**Anemia**		**Circle all that applies Diphtheria/Rubella/Tetanus**	
Kidney Problems		**Arthritis**		**Venereal Disease**	
Heart Failure		**Osteoporosis**		**HIV / AIDS**	
Heart Attack		**Gallbladder Disease**		**Hepatitis**	

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COMPLETE ALL SHADED AREAS

COMPLETE ALL SHADED AREAS ABOVE

NAME:_____**DOB**:_____

Primary Care Physician:_____**Ph#**_____**Fx#**_____

Pharmacy Name:_____**Location:**_____

Phone#:_____**FAX:#**_____

DIAGNOSIS: **(for office use)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

MEDICATIONS: **(include strength and how often a day)**

1 _____
2_____
3 _____
4_____
5 _____
6 _____
7_____
8_____
9_____
10_____
11_____
12_____
13 _____
14_____

ALLERGIES:_____

_____